PRIOR AUTHORIZATION (PA) Request Form

Fax completed form to 888-972-1931

Please note*: *Incomplete request form without supporting clinical notes will delay the determination process. Determination Notification will be sent to the member, the requesting provider, the member's PCP (if different than the requesting) and the requested provider.

IPA NAME: _____

Type of Request: *circle one* **ROUTINE** **URGENT***(medical condition that requires immediate intervention only*) **RETRO**

MEMBER INFORMATION **Date:**

Patient Name:_____Gender: M / F Date of Birth:_____

Patient's Address:_____

Street City Zip

Phone:_____Health Plan: _____

Subscriber Name:_____Subscriber #_____

Member's Primary Care Provider: _____

REQUESTING PROVIDER	REQUESTED PROVIDER & FACILITY
Name:	Name:
Type of Specialty:	Type of Specialty:
Address:	Address:
City, State, ZIP:	City, State, ZIP:
Phone: Fax:	Phone: Fax:
Contact Name:	Tax ID # (Non-Contracted Providers only):
Today's Date:	Place of Service:

REQUESTED SERVICES AND MEDICAL NECESSITY

Diagnosis Description(s):_____

ICD10(s):_____

Reason for Referral:_____

Attach supporting documentation to support requested service (s): *(recent clinical notes, physical exam, labs, Diagnostic study results, pictures/images with measurements)*

_____

Requested Service(s): Description:_____CPT:_____# Units_____

Description:_____CPT:_____# Units_____

Description:_____CPT:_____# Units_____

Description:_____CPT:_____# Units_____

- Approved authorizations are effective from the date they are received and expire three (3) months from the effective date
- and are based on the member's eligibility at the time the authorization is reviewed.
- Providers are responsible to verify member eligibility to ensure coverage. Approved Authorization is not a guarantee of payment.
- Claims for services rendered without required prior authorization may be denied reimbursement.
- Claims for the above services must be submitted for the same service, CPT code and provider group (tax id #) as those approved or documentation must be submitted to explain the medical necessity of alternative and/or additional services. The requesting physician or the member may submit authorization appeals to Premier Patient Care IPA- UM Dept at fax at 888-972-1931. For any questions, please call our **UM Department at (657)-206-8700 select Outpatient Authorization.**

This is confidential and privileged information protected by California Civil Code § 43.97, Health & Safety code §1370, and California Evidence Code § 1157.

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